acknowledge the limitations of EMR and personal skills, know when to request help, and understand the principles of quality measurement and improvement.[9,10] Trainees should be familiar with the appropriate management of anticoagulation in the setting of a mucosal resection, taking into consideration the potential risk of delaying reinitiation of anticoagulants or antiplatelet agents.[11] Additionally, trainees need to clearly communicate findings, treatment performed, postprocedure instructions, and follow-up recommended to the patient and family and to communicate to the referring and primary physicians.

recognition of lesions that are not amenable to EMR, including findings that suggest unresectability that may be discovered during the procedure.

Furthermore, marking the area to be resected using thermal marking or other approaches should be taught. Trainees should understand and be able to perform 1 or more of the various techniques currently used for EMR. Trainees should know the advantages of the available distal endoscopic attachments, such as oblique and straight caps, in various GI tract organs. Trainees should be taught appropriate electrosurgery settings and how to change the settings based on the morphologic types of the lesion and resultant tissue effect.

Cap- and band ligation–assisted EMR are often used in esophageal EMR. Trainees should know how to set up the EMR kit before the procedure and understand differences between the 2 techniques. In cap-assisted EMR, submucosal injection is performed first, and a crescent-shaped

4.